STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Renée D. Coleman-Mitchell, MPH
Commissioner

Ned Lamont
Governor

Susan Bysiewicz
Lt. Governor

Healthcare Quality And Safety Branch

June 6, 2019

Peter Adamo, Administrator
Waterbury Hospital
64 Robbins Street
Waterbury, CT 06721

Dear Mr. Adamo:

Unannounced visits were made to Waterbury Hospital on April 5, 8 and 24, 2019 by representatives of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting an investigation, and a certification inspection.

Attached are the violations of the Regulations of Connecticut State Agencies and/or General Statutes of Connecticut which were noted during the course of the visits.

In accordance with Connecticut General Statutes, section 19a-496, upon a finding of noncompliance with such statutes or regulations, the Department shall issue a written notice of noncompliance to the institution. Not later than ten days after such institution receives a notice of noncompliance, the institution shall submit a plan of correction to the Department in response to the items of noncompliance identified in such notice.

The plan of correction is to be submitted to the Department by June 20, 2019.

The plan of correction shall include:

(1) The measures that the institution intends to implement or systemic changes that the institution intends to make to prevent a recurrence of each identified issue of noncompliance;

(2) the date each such corrective measure or change by the institution is effective;

(3) the institution's plan to monitor its quality assessment and performance improvement functions to ensure that the corrective measure or systemic change is sustained; and

(4) the title of the institution's staff member that is responsible for ensuring the institution's compliance with its plan of correction.

The plan of correction shall be deemed to be the institution's representation of compliance with the identified state statutes or regulations identified in the department's notice of noncompliance. Any institution that fails to submit a plan of correction may be subject to disciplinary action.

You may wish to dispute the violations and you may be provided with the opportunity to be heard. If the violations are not responded to by June 20, 2019 or if a request for a meeting is not made by the stipulated date, the violations shall be deemed admitted.

An office conference has been scheduled for July 2, 2019 at 1:00PM in the Facility Licensing and Investigations Section of

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the Department of Public Health, 410 Capitol Avenue, Second Floor, Hartford, Connecticut. Should you wish to retain legal representation, your attorney may accompany you to this meeting. Please be prepared to discuss those violations identified with an asterisk.

Alternate remedies to violations identified in this letter may be discussed at the office conference. In addition, please be advised that the preparation of a Plan of Correction and/or its acceptance by the Department of Public Health does not limit the Department in terms of other legal remedies, including but not limited to, the issuance of a Statement of Charges or a Summary Suspension Order and it does not preclude resolution of this matter by means of a Consent Order.

Should you have any questions, please do not hesitate to contact this office at (860) 509-7400.

Respectfully,

Susan Newton, RN, BS
Supervising Nurse Consultant
Facility Licensing and Investigations Section

SHN:mb

Complaint #25221

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D3 (a) Physical Plant (4) and/or (b) Administration (2) and/or (e) Nursing Service (1) and/or (i) General (6)

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and/or Connecticut General Statutes 19a-550.

1. *Based on clinical record reviews, facility documentation, interviews and policy review, for 2 of 14 patients (Patient #1 and #2) admitted with suicidal ideation and/or self-harm tendencies, the facility failed to ensure that the patients were cared for in a safe environment to prevent self-harm. The findings include the following:
   a. Patient #1 presented to the facility on 3/23/19 via ambulance on a Physician Emergency Certificate (PEC) from the mobile crisis unit. The patient was admitted to the in-patient behavioral health unit on 3/25/19 with a diagnosis of depression and suicidal ideations. Patient #1 was noted to be anemic requiring medical intervention and was discharged to a medical unit on 3/27/19 for treatment.
   Review of a discharge summary dated 3/27/19 indicated that Patient #1 had been admitted to the behavioral health unit on 3/23/19 with suicidal ideation and indicated that the patient had made three suicide attempts in the past several weeks. While on the behavioral health unit Patient #1 was on every fifteen minute safety checks. During admission, the patient was noted to have anemia, a medical consult was obtained and the decision was made to discharge the patient to a medical floor for treatment.
   Patient #1's physician discharge orders dated 3/27/19 at 8:00 PM directed 1:1 observation.
   A psychiatric consult dated 3/28/19 at 3:23 PM indicated that the patient reported feeling safe while in the hospital and denied any intent or plan to harm him/her self on the (medical) unit. The note indicated that the patient had been communicating effectively on the unit and MD #1 discontinued the 1:1 observation. MD #1 indicated that once medically cleared, Patient #1 would be readmitted to the behavioral health unit.
   A nurse's note dated 3/28/19 at 10:21 PM indicated that at 8:55 PM Patient #1 asked to take a shower but RN #1 told the patient no, due to safety concerns. The note indicated that at 9:00 PM, RN #1 found the patient's bathroom door locked and there was no response. RN #1 unlocked the door and found Patient #1 hanging by a belt in the shower.
   Review of Patient #1's clinical record identified that the patient was intubated and treated in the intensive care unit. Life saving measures were unsuccessful and the patient expired on 3/30/19.
   Interview with RN #1 on 4/8/19 at 10:00 AM indicated that she was assigned to Patient #1 on 3/28/19. RN #1 indicated that the patient was alert and oriented and denied any suicidal ideation. RN #1 stated she and the charge nurse spoke about the patient and decided to move the patient closer to the nurse's station for better visibility after the 1:1 was removed. RN #1 further indicated that at approximately 8:50 PM-8:55 PM the patient asked to use the shower and she informed him/her that s/he couldn't get his/her IV site wet and provided washcloths and towels. RN #1 stated she went to the room next door and upon exiting the room noted Patient #1's room was dark and the TV was off. RN #1 entered the room and noted that the patient was not in the bed and the bathroom door was locked. RN #1 stated she called a code and while going for the crash cart another RN and PCA entered the room, opened the bathroom door and found Patient #1 hanging from the shower rod. Staff lowered the patient to the floor and CPR was initiated. Review of the code sheet indicated that the code was called at 9:00 PM.
   Interview with MD #1 indicated that he had seen Patient #1 on 3/28/19 at approximately

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4:00 PM. MD #1 indicated that based on his evaluation the patient was not suicidal and the 1:1 supervision was discontinued. MD #1 stated he was not aware that Patient #1's belonging were sent with the patient when the patient is discharged to a medical floor, and if he would have known that Patient #1 was given possession of his/her belongings (belts/shoe laces) on the medical floor, it would have impacted his decision regarding the patient's level of supervision. MD #1 indicated that prior to the event the hospital did not have a policy related to patient belongings. Following the event a policy was instituted on 4/1/19 to ensure that when a patient is transferred off of the BH unit, their belongings are not returned to them until the behavioral health treatment team reviews the patient's situation.

The hospital failed to effectively communicate to the physician that the patient's belongings were returned upon transfer from the psychiatric unit to the medical unit and/or had a policy that directed this practice.

b. Patient #2 presented to the Emergency Department (ED) on 3/27/19 at 9:30 PM with suicidal ideation. Review of the triage assessment indicated that the patient verbalized self-harm. The suicide assessment (P4) indicated that the patient was a high risk for suicide resulting in the need for 1:1 observation per the triage protocol. A physician's order dated 3/27/19 at 9:41 PM directed continuous observation. When Patient #2 was transferred to the ED behavioral health area on 3/28/19 at 1:00 AM the patient was monitored every 15 minutes. The hospital failed to institute continuous observation of the patient in accordance with the physician's order.

Review of the clinical record identified that the patient was seen by the Crisis Worker on 3/28/19 at 9:11 AM who indicated that the patient was a "high" risk for suicide. The Behavioral Health progress note dated 3/28/19 at 12:27 PM indicated that at approximately 12:15 PM, Patient #2 went to the common bathroom located off the main hallway and was in the bathroom for five plus minutes. The note indicated that the RN was at lunch and that the door to the crisis room was left open to be present for patients. Security Guard (SG) #3 was at the desk. Security Guard (SG) #2 heard gasping sounds coming from the bathroom, went to the bathroom door, knocked and then opened the door. SG #2 found Patient #2 on the floor with his/her socks tied together around his/her neck and tied around the toilet paper dispenser.

A nurse's note dated 3/28/19 at 12:27 PM indicated that Patient #2 was found by SG #2 in the behavioral health bathroom gasping for air with a sock tied around his/her neck and tied around the toilet paper holder. Patient #2 was alert and oriented, tearful, no redness to neck noted, lungs were clear to auscultation, and the patient was complaining of a headache and neck soreness. The patient was transferred to the main ED, for a complete medical assessment and a 1:1 sitter was at the patient's bedside. A CT scan of the neck was completed, which was negative.

Interview with Security Guard #2 on 4/24/19 at 9:30 AM indicated that he was a shift supervisor and in his role he rounds on the security guards throughout the day. SG #2 indicated that on 3/28/19 he went to the behavioral health ED and was rounding, checking with the security guard on duty and looking at the video cameras (of the patients in the behavioral health ED). SG #2 asked SG #3 (who was stationed in the behavioral health ED and the nurse was on lunch break) where Patient #2 was, and was informed that the patient was in the bathroom. SG #2 went to the bathroom and knocked. When there was

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no answer he listened at the door, heard gagging and announced he would be opening the door. SG #2 indicated that when he opened the door Patient #2 was on the floor with his/her head against the wall and he identified that the patient had tied the hospital issued socks together and tied them around the toilet paper dispenser and around his/her neck. SG #2 indicated that the patient was gagging and when he removed the socks the patient took a deep breath and was speaking with no issues. SG #2 yelled for help and assisted transferring the patient.

Interview with SG #1 on 4/8/19 at 11:00 AM, and SG #2 on 4/24/19 at 9:30 AM indicated that while in the behavioral health ED their responsibility is to monitor the patients and the environment every 15 minutes. SG's #1 and #2 indicated that they had no training on the facility policies related to patient observation.

Interview with the Director of Security on 4/24/19 at 12:30 PM stated that SG #3 was trained to complete fifteen minute safety and environmental checks, and not continuous observation as ordered.

Interview with the Behavioral Health Manager on 4/8/19 at 10:00 AM indicated that when a patient requests to use the bathroom in the behavioral health ED the patient should be in sight at all times and this was not done.

Interview with the Director of Quality on 4/24/19 at 2:00 PM indicated that it was identified after the incident that the term "Continuous" observation was not in the hospital observation policy. The practice was that continuous observation meant direct line of site, and security guards conducted fifteen minute checks and this was how the behavioral health ED functioned. Additionally the Director identified that staff in the ED were confusing "continuous" observation and "constant" when ordering observation status and that the ED and behavioral health ED staff were re-educated on 4/2/19.

Review of the patient observation policy in place at the time of the incident identified that an observation status is assigned to the behavioral health patient on admission to the behavioral health ED and to the inpatient unit. The policy identified two levels of observation, fifteen minute checks and/or constant staff companion. The category of "continuous" which was ordered for Patient #2 was not identified in the policy.

The hospital failed to ensure that the patient was in line of sight at all times in accordance with the physician's order and as a result, the patient attempted suicide. Immediate Jeopardy was identified on 4/24/19. Based on the following action plan, Immediate Jeopardy was verified as being corrected as of 4/2/19.

Following the incidences involving Patients #1 and #2, the hospital instituted corrective measures that included the development of a psychiatric patient belonging policy, revision of the patient observation policy on 4/2/19 to include continuous observation. The policy indicated that continuous observation required the patient to be in full visual contact by a trained staff member, including when the patient was using the bathroom. The main ED and behavioral health ED staff were re-educated on the revised policy on 4/2/19. Staffing in the behavioral health ED was changed on 3/29/19 from 2 staff to 3 to include a RN, a security guard and Patient Care Technician who would be available to assist patients with personal needs.

Based on clinical record review, interview and policy review for 1 of 1 patients requiring observation for suicidal ideation (Patient #2) the facility failed to ensure that qualified staff

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conducted the monitoring. The finding includes the following:

Patient #2 presented to the Emergency Department (ED) on 3/27/19 at 9:30 PM with suicidal ideation. Review of the triage assessment indicated that the patient verbalized self-harm. The suicide assessment (P4) indicated that the patient was a high risk for suicide resulting in the need for 1:1 observation per the triage protocol. A physician's order dated 3/27/19 at 9:41 PM directed continuous observation. When Patient #2 was transferred to the ED behavioral health area on 3/28/19 at 1:00 AM the patient was monitored every 15 minutes, per unit process, and not in accordance with the physician's order.

Review of the clinical record indicated that Patient #2 was seen by the Crisis Worker on 3/28/19 at 9:11 AM who indicated that the patient was a "high" risk for suicide. A behavioral health progress note dated 3/28/19 at 12:27 PM indicated that at approximately 12:15 PM Patient #2 was found in the bathroom with his/her socks tied together around his/her neck and tied around the toilet paper dispenser.

The 3/28/19 progress note at 12:27 PM indicated that the patient was alert and oriented and brought to room 16 (main ED) after being found by security in the behavioral health bathroom with a sock tied around his/her neck and tied around toilet paper holder in the bathroom. Review of the physician's order dated 3/28/19 at 12:29 PM directed 1:1 observation. The nurse's note dated 3/28/19 at 1:24 PM indicated that the patient removed the hub from his/her IV and was bleeding from the IV site.

Interview with Security Guard #1 on 4/8/19 at 11:00 AM indicated that he was instructed to sit with Patient #2 on 3/28/19 after the patient tried to hurt self in the behavioral health ED. SG #1 indicated that he was sitting next to the patient and the patient was fiddling under the blankets but he did not feel comfortable removing the blanket. SG #1 informed the nurse when he saw her, however, was unable to identify the timeframe for the notification. Upon removal of the blanket by the RN, it was identified that the patient had removed the cap from the IV and was bleeding. SG #1 stated that he had never been trained on how to be a 1:1 companion but was told he had to go for education "this week". Review of SG #1's personnel file with the Healthstream Coordinator on 4/8/19 at 2:00 PM indicated that there is no formal education provided for performing patient observation, sitting or constant, and that this would be "on the job training".

Interview with Security Guard #2 on 4/24/19 at 9:30 AM indicated that he is the shift supervisor and explained that the security guards role in the behavioral health ED is to complete fifteen minute checks on patients and safety & environmental checks. The facility failed to ensure security staff were trained to conduct 1:1 observations as directed.

Interview with the Director of Security on 4/24/19 at 12:30 PM stated that SG #1 was assigned to watch the patient but did not have specific training in what to watch for, including but not limited to having the patients hands visible at all times, and would not expect the guard to lift the blanket.

Subsequent to this incident all security staff, RN's and PCA's were re-educated on the new patient observation policy which was completed on 4/2/19.

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D3 (d) Medical Records (3) and/or (e) Nursing Service (l).

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2. Based on clinical record reviews, interviews and review of facility policy for three of three sampled patients (Patients # 10, 11, 12) who were reviewed for the use of physical restraints, the facility failed to ensure restraint documentation was complete. The findings include:
   a. Patient #10 was evaluated in the Emergency Department (ED) with a diagnosis of suicidal ideations (SI) and poly substance abuse. A physician's order dated 3/12/19 at 10:05 PM directed the application of soft, locked, four point restraints for physical abuse towards others. Restraint monitoring documentation from 3/12/19 at 10:05 PM to 11:05 PM identified every fifteen minute safety checks had been completed. However, the medical record lacked documentation identifying the behaviors necessitating the continued use of the restraint, the patient's readiness for discontinuation, and/or the least restrictive methods attempted.
   b. Patient #11 was evaluated in the ED on 3/11/19 at 7:54 PM for inappropriate behaviors such as agitation, head banging, screaming, combativeness and spitting at staff. A physician's order dated 3/11/19 at 8:06 PM directed the application of soft, locked, four point restraints for physical abuse toward others and checks every fifteen minutes while restrained. Restraint monitoring documentation from 3/11/19 at 8:06 PM to 11:01 PM identified every fifteen minute safety checks had been completed. However, the medical record lacked documentation identifying the behaviors necessitating the continued use of the restraint, the patient's readiness for discontinuation and/or the least restrictive methods attempted.
   c. Patient #12 was evaluated in the ED on 3/23/19 at 4:21 AM for aggressive, uncooperative, and violent behavior. A physician's order dated 3/23/19 at 9:40 AM directed the application of soft, locked, four point restraints for physical abuse toward others and P#12 was to be on constant observation. Restraint monitoring documentation from 3/23/19 from 10:57 to 11:55 identified every fifteen minute safety checks had been completed. However, the medical record lacked documentation identifying the behaviors necessitating the continued use of the restraint, the patient's readiness for discontinuation and/or the least restrictive methods attempted.

      Review of the clinical records with the Behavioral Health Nurse (RN#2) on 4/8/19 at 1:00 PM identified that assessments were completed by nursing every two hours.

      During a review of the clinical records and the facility policy on 3/8/19 at 1:00 PM with the Director of Performance Improvement s/he was unable to provide documentation that assessments of the patient's behaviors to justify the continued need for restraints had been completed every fifteen minutes. Additionally, s/he indicated that prior to the electronic medical record program the behaviors necessitating the continued use of the restraint, the patient's readiness for discontinuation and/or the least restrictive methods attempted were documented on a separate flow sheet.

      Review of the facility's restraint monitoring policy directed staff to document safety checks of the patient at least every fifteen minutes while restrained. Safety checks included assessing the patient for signs of injury, nutrition/hydration, circulation, range of motion, hygiene, elimination, affect, the patients readiness for discontinuation of the restraint or the behavior necessitating the restraint's continued use.

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(6).

3. *Based on clinical record reviews, review of facility documentation, review of policies/procedures, interviews, and tour of the facility for 1 of 10 patients reviewed for suicidal ideations and safety needs (Patient #2) the facility failed to ensure that the patient was cared for in a psychiatrically safe environment which resulted in a finding of Immediate Jeopardy. Immediate Jeopardy was verified as corrected as of 4/2/19. The finding includes:
   a. Patient #2 presented to the Emergency Department (ED) on 3/27/19 at 9:30 PM with suicidal ideation. Review of the triage assessment indicated that the patient verbalized self-harm. The suicide assessment (P4) indicated that the patient was a high risk for suicide resulting in the need for 1:1 observation per the triage protocol. A physician's order dated 3/27/19 at 9:41 PM directed continuous observation. When Patient #2 was transferred to the ED behavioral health area on 3/28/19 at 1:00 AM the patient was monitored every 15 minutes. The hospital failed to institute continuous observation of the patient in accordance with the physician's order.
   Review of the clinical record identified that the patient was seen by the Crisis Worker on 3/28/19 at 9:11 AM who indicated that the patient was a "high" risk for suicide. The Behavioral Health progress note dated 3/28/19 at 12:27 PM indicated that at approximately 12:15 PM, Patient #2 went to the common bathroom located off the main hallway and was in the bathroom for five plus minutes. The note indicated that the RN was at lunch and that the door to the crisis room was left open to be present for patients. Security Guard (SG) #3 was at the desk. Security Guard (SG) #2 heard gasping sounds coming from the bathroom, went to the bathroom door, knocked and then opened the door. SG #2 found Patient #2 on the floor with his/her socks tied together around his/her neck and tied around the toilet paper dispenser.
   A nurse's note dated 3/28/19 at 12:27 PM indicated that Patient #2 was found by SG #2 in the behavioral health bathroom gasping for air with a sock tied around his/her neck and tied around the toilet paper holder. Patient #2 was alert and oriented, tearful, no redness to neck noted, lungs were clear to auscultation, and the patient was complaining of a headache and neck soreness. The patient was transferred to the main ED, for a complete medical assessment and a 1:1 sitter was at the patient's bedside. A CT scan of the neck was completed, which was negative.
   Interview with Security Guard #2 on 4/24/19 at 9:30 AM indicated that he was a shift supervisor and in his role he rounds on the security guards throughout the day. SG #2 indicated that on 3/28/19 he went to the behavioral health ED and was rounding, checking with the security guard on duty and looking at the video cameras (of the patients in the behavioral health ED). SG #2 asked SG #3 (who was stationed in the behavioral health ED and the nurse was on lunch break) where Patient #2 was, and was informed that the patient was in the bathroom. SG #2 went to the bathroom and knocked. When there was no answer he listened at the door, heard gagging and announced he would be opening the door. SG #2 indicated that when he opened the door Patient #2 was on the floor with his/her head against the wall and he identified that the patient had tied the hospital issued socks together and tied them around the toilet paper dispenser and around his/her neck. SG #2 indicated that the patient was gagging and when he removed the socks the patient took a

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deep breath and was speaking with no issues. SG #2 yelled for help and assisted transferring the patient.

Interview with the Director of Security on 4/24/19 at 12:30 PM stated that SG #3 was trained to complete fifteen minute safety and environmental checks, and not continuous observation as ordered.

Review of the Risk Assessment dated January 2019 identified that the toilet paper holders were recessed and designed for use without a paper roll.

Interview with Nurse Manager on 4/5/19 at 9:30 AM identified that the toilet paper holder in the bathroom of the behavioral health ED had not been identified as a ligature risk prior to 3/28/19.

The hospital failed to ensure that the environment was safe preventing patient injury.

Immediate Jeopardy was identified on 4/24/19 and verified as corrected as of 4/24/19 based on the implementation of their action plan.

Following the incident on 4/2/19, the hospital instituted corrective measures that included removal the toilet paper holder in the BH ED and on the Behavioral Health inpatient unit. Door handles (31) were changed in the BH ED and on the inpatient BH unit, phone cords on the BH unit were shortened, sink faucets on the inpatient BH unit were changed and door latches were removed. A check list was developed to be completed for patients identified as high risk for suicide outside of the BH Units to ensure that potential ligature risks were removed.